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EXAMINER

RANGREJ, SHEETAL

ART UNIT

PAPER NUMBER

3626

MAIL DATE

DELIVERY MODE

05/03/2007

PAPER

Please find below and/or attached an Office communication concerning this application or proceeding.

The time period for reply, if any, is set in the attached communication.

Office Action Summary

Application No.

10/608,254

Applicant(s)

BALOGH, MARY

Examiner

Sheetal R. Rangrej

Art Unit

3626

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

- 1) ☒ Responsive to communication(s) filed on 02/07/2007.
- 2a) ☒ This action is **FINAL**. 2b) ☐ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

- 4) ☒ Claim(s) 1-17 is/are pending in the application.
- 4a) Of the above claim(s) _____ is/are withdrawn from consideration.
- 5) ☐ Claim(s) _____ is/are allowed.
- 6) ☒ Claim(s) 1-17 is/are rejected.
- 7) ☐ Claim(s) _____ is/are objected to.
- 8) ☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on _____ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.
Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).
Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).
- 11) ☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

- 12) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All b) ☐ Some * c) ☐ None of:
- ☐ Certified copies of the priority documents have been received.
 - ☐ Certified copies of the priority documents have been received in Application No. _____.
 - ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

- 1) ☒ Notice of References Cited (PTO-892)
- 2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
- 3) ☐ Information Disclosure Statement(s) (PTO/SB/08)
Paper No(s)/Mail Date _____
- 4) ☐ Interview Summary (PTO-413)
Paper No(s)/Mail Date _____
- 5) ☐ Notice of Informal Patent Application
- 6) ☐ Other: _____

DETAILED ACTION

Notice to Applicant

1. This communication is in response to the amendment filed on 02/15/2007. Claims 1-17 are pending. Claims 1-5, 9, 10, 12, 14, 15, and 17 are amended.

Drawings

2. Pursuant to applicant's submission, the examiner has withdrawn the objections made against the drawing.

Specification

3. Pursuant to applicant's submission, the examiner has withdrawn the objections made against the specification.

Claim Rejections - 35 USC § 112

4. In regards to applicant's amendment, the examiner has withdrawn the 35 USC 112, second paragraph rejections made against claim 5.

5. The following is a quotation of the second paragraph of 35 U.S.C. 112:

The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

6. Claims 4 and 12 are rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention.

7. Claims 4 recites, "translating said interpreted received nonpayment code to said standard activity code." The examiner is unable to determine the difference between a nonpayment code and a standard activity code, because the specification defines the standard activity code referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an

industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). For examination purposes, the examiner will interpret the nonpayment code to be the same as a standard code.

The examiner requests that if the applicant has a different definition for nonpayment code, then the applicant should make a record of and show where in the specification it provides support for the definition.

8. Claim 12 recites, "said rejected claim data was accompanied by a denial or rejection notification." Applicant admits "the difference between denials and rejections is that the payer absolutely will not pay on the payment request for a denial, and that the payer may pay on the payment request for a rejection if the reason for the rejection is corrected" (Application, page 8, 14-19). Based on this admission, the examiner is unable to determine how the rejected claim data could be accompanied by a denial notification. For examination purposes, the examiner will interpret the claim data to be accompanied by denial or rejection notification.

Claim Rejections - 35 USC § 103

9. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negated by the manner in which the invention was made.

10. Claims 1-2, 12-14, and 16-17 are rejected under 35 U.S.C. 102(e) as being unpatentable by Provost et al. (U.S. Patent 6,341,265) in view of Pritchard (U.S. Patent 4,491,725).

11. As per claim 1, Provost teaches a method for processing claim data comprising the steps of:

Art Unit: 3626

- a. Selecting an activity code from a predetermined activity code set identifying processing to be performed concerning claim data (Provost: column 6, lines 2-11). In light of the specification, the examiner interprets the “diagnosis code and the treatment code” to be the same as an activity code from a predetermined set of codes.
- b. Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected (Provost: column 4, lines 24-27; column 13, lines 45-54) claim data.
- c. Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one: amended rejected claim data (Provost: column 4, lines 27-35).
- d. Preparing said corrected claim data for submission to a payer organization (Provost: column 4, lines 35-38).

Provost does not explicitly teach including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization.

Applicant has amended claim 1, by adding the limitation preparing said corrected claim data by including a standard activity code from a standard activity code set different to internal activity code set and facilitating compatible communication between a particular organization and a payer organization. As per this element, it is evidenced by Pritchard (U.S. Patent No. 4,491,725) that CPT-IV code (i.e. standard activity card) is different from the four-digit service code (i.e. internal code), and also facilitates compatible communication through the data terminal (Pritchard: col. 8, 11-52).

Applicant has further amended claim 1, by adding the limitation to automatically provide an internal activity code to rejected claim data and scheduling a task to derive corrected claim data. As per this element, as evidenced by Pritchard, it is well known in the claims processing art to, automatically or manually, assign diagnostic or procedural codes (i.e. claim data) to internal operational codes or nomenclature specific to an insurance company or hospital operation. The examiner interprets that an appropriate error message, as in Pritchard, is the same as assigning a particular internal code to a rejected claim data. The examiner also interprets that the service provider correcting the form after the error message is sent is the same as a task being scheduled in response to assigned internal activity code. (Pritchard: col. 8, 4-52)

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost and Pritchard. One of ordinary skill would have been motivated to combine these teachings because routine processing of an insurance form can take many weeks and substantial time before the patient or medical service provider receives a reimbursement for the medical expense (Pritchard: col. 1, 21-25). It is further motivated to combine because insurance carriers develop fee payment schedules, which determine the fee that they will pay for each particular type of service. These tables are generally complex and involve hundreds of items dependent on several factors. (Pritchard: col. 1, 59-col. 2, 14). Hence, the automation reduces the rejections of claims.

12. As per claim 2, Provost teaches the method of claim 1 is as described above. Provost further teaches a set of codes identifying a nonpayment reason comprising at least one of: a rejection activity code and a denial activity code (Provost: column 10, lines 53-63).

Applicant has amended claim 2, by adding the limitation the predetermined internal activity code set is different from a set of code identifying nonpayment reason. As per this element, it is evidenced by Pritchard as discussed with regard to claim 1. The appropriate error message is the same as set of codes for a nonpayment reason and the conversion of CPT-IV code to four-digit service code for the selected insurance carries to be the same as the internal activity code.

13. As per claim 12, the method of claim 1 is as described above.

Provost further teaches determining from said notification whether said rejected claim data was denied or rejected (Provost: column 6, lines 12-15). In light of the specification, the examiner interprets “determination of the submitted claim will not be paid by an insurer” to be the same as a rejected claim data.

Provost further teaches selecting a first activity code (Provost: column 6, lines 2-7) in response to a denial notification and a different second activity code (column 6, lines 2-7) in response to a rejection notification (Provost: column 4, lines 7-16 and lines 52-55). In light of the specification, the examiner interprets “diagnosis code” to represent “first activity code” and “treatment code” to represent “second activity code.” In light of the specification, the examiner also interprets “feedback almost immediately to the medical technician specifying whether a submitted claim is in condition to be paid” to be the same as a notification for either a denial or a rejected claim.

Provost explicitly does not teach a first internal code to a denial notification and a second internal activity code to a rejection notification.

Art Unit: 3626

Applicant has amended claim 12, by adding the limitation a first internal code to a denial notification and a second internal activity code to a rejection notification. As per this element, it is evidenced by Pritchard that each CPT-IV code is converted to a service code for a particular insurance carrier. The examiner interprets that the codes that are denied by the insurance carrier, meaning the insurance carrier does not have a match for that code, will have first internal code and the codes that are rejected, meaning the insurance carrier does not pay for that service, will have a second internal code. (Pritchard: col. 8, 11-52)

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost and Pritchard with the same motivation as discussed for claim 1.

14. As per claim 13, the method of claim 1 is as described above.

Provost further teaches said method steps are performed automatically and at least one of excluding manual intervention (Provost: column 6, lines 47-62) by one or more healthcare workers.

15. As per claim 14, the method for processing claim data comprising the steps of:

- a. Identifying a nonpayment code, associated with a predetermined nonpayment code set (Provost: column 10, lines 57-63). In light of the specification, the examiner interprets the "informing that the treatment code is inconsistent" to be the same as identifying a nonpayment activity code.
- b. Selecting an activity code from a predetermined activity code set identifying processing to be performed concerning claim data (Provost: column 6, lines 2-11). In

light of the specification, the examiner interprets the “diagnosis code and the treatment code” to be same as an activity code from a predetermined set of codes.

- c. Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected (Provost: column 4, lines 24-27; column 13, lines 45-54) claim data.
- d. Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one: amended rejected claim data (Provost: column 4, lines 27-35).
- e. Preparing said corrected claim data for submission to a payer organization (Provost: column 4, lines 35-38).

Applicant has amended claim 14, providing the same limitations as claim 1. Please see discussion for claim 1 above.

16. As per claim 16, the method of claim 14 is as described above. Provost further teaches predetermined nonpayment code set compatible with a HIPAA standard code set (Provost: column 6, lines 2-6). According to HIPAA law, the term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

17. As per claim 17, Provost teaches a system for processing claim data for reimbursement of provision of healthcare to a patient in response to rejection, denial, or lack of response to a submitted claim, comprising:

- a. A workflow processor for,
 - (1) Selecting an activity code from a predetermined activity code set including a plurality of codes identifying processing to be performed

concerning rejected claim data in response to a received notification of claim denial or rejection (Provost: column 6, lines 2-11);

(2) Assigning said selected activity code (Provost: column 6, lines 4-5) to rejected claim data (Provost: column 4, lines 24-27; column 13, lines 45-54) associated with said received notification;

(3) Scheduling a task comprising performing processing concerning said rejected claim data to derive corrected claim data including at least one (b) amended rejected claim data (Provost: column 4, lines 27-35), in response to said assigned selected activity code; and

(4) An interface processor for preparing said corrected claim data for submission to a payer organization for payment (Provost: column 7, lines 20-27).

Applicant has amended claim 17, providing the same limitations as claim 1. Please see discussion for claim 1 above.

18. Claims 3-5 and 15 are rejected under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent 6,341,265) in view of Giannini (U.S. Patent 5,915,241), and further in view of Pritchard (U.S. Patent 4,491,725).

19. As per claim 3, the method of claim 1 is as described. The Provost patent further teaches receiving a nonpayment code comprising at least one of: a rejection code and a denial code (Provost: column 10, lines 57-63). The specification defines the standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open

Art Unit: 3626

activity code, and the like (page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the “informing that the treatment code is inconsistent” to be the same as receiving a nonpayment activity code.

Provost does not teach said selecting step comprises interpreting said received nonpayment code to determine from said predetermined activity code set, an activity code compatible with said nonpayment code.

Giannini teaches said selecting step comprises interpreting said received nonpayment code to determine from said predetermined activity code set, an activity code compatible with said nonpayment code (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be the same as nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that “as alternative medicine is brought into mainstream medicine, alternative providers have attempted to use these codes, but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, “dummy billing codes” or codes designed by individual payers to cope with payment for alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine” (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

Applicant has amended claim 3, providing the same limitations as claim 1. Please see discussion for claim 1 above.

20. As per claim 4, the method of claim 1 is as described. The Provost patent further teaches receiving a nonpayment code comprising at least one of: a rejection code (Provost: column 10, lines 57-63). The specification defines the standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the "informing that the treatment code is inconsistent" to be the same as receiving a rejected nonpayment activity code.

Provost does not teach interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with said nonpayment code set employed by an organization.

Giannini teaches interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with a predetermined nonpayment code set employed by an organization (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that as alternative medicine is brought into mainstream medicine, alternative

providers have attempted to use these codes; but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, "dummy billing codes" or codes designed by individual payers to cope with payment for alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

21. As per claim 5, the method of claim 4 is as described above.

The Provost patent does not teach predetermined nonpayment code set includes fewer codes than a code set used to derive said received nonpayment code.

The Giannini patent teaches predetermined nonpayment code set (Giannini: column 1, lines 53-62) includes fewer codes (Giannini: column 2, lines 13-16) than a code set used to derive said received nonpayment code (Giannini: column 2 lines 1-8). In light of the specification, the examiner interprets "CPT codes", "codes by individual payers", and "description codes" to be the same as a nonpayment code. The examiner also interprets "description codes are not comprehensive and fail to account for all services" to be the same as the predetermined description code set (nonpayment code) to be fewer than the received service codes.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Giannini with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that in cases where certain specialties perform procedures which cross many sub-specialties, the procedures fall into more than one of the numerated rubrics of CPT codes

and the burden on the practitioner to learn the proper classification becomes particularly undue (Giannini: column 3, lines 14-20).

Provost and Giannini do not explicitly teach translating nonpayment code to an internal activity code.

Applicant has amended claim 5, by adding the limitation translating nonpayment code to an internal activity code. As per this element, it is evidenced by Pritchard that CPT-IV (i.e. nonpayment code) is translated into a four-digit service code (i.e. internal activity code) for the selected insurance carrier. CPT-IV is a nonpayment code due to the fact that the service was provided to the patient, yet has not been paid because it first needs to be translated by the insurance carrier to determine how much the patient owes.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time the invention was made to combine the teachings of Provost in view of Giannini with Pritchard. One of ordinary skill would have been motivated to combine these teachings because routine processing of an insurance form can take many weeks and substantial time before the patient or medical service provider receives a reimbursement for the medical expense (Pritchard: col. 1, 21-25). It is further motivated to combine because insurance carriers develop fee payment schedules, which determine the fee that they will pay for each particular type of service. These tables are generally complex and involve hundreds of items dependent on several factors. (Pritchard: col. 1, 59-col. 2, 14). Hence, the automation reduces the rejections of claims.

22. As per claim 15, the method of claim 14 is as described above.

Provost further teaches receiving a nonpayment code comprising at least one of: a rejection code and a denial code (Provost: column 10, lines 57-63). The specification defines the

standard activity code for the rejection or denial communications is otherwise referred to as a predetermined nonpayment activity code, a known activity code, a public activity code, an industry activity code, an open activity code, and the like (page 9, lines 31-33 and page 10, line 1). In light of the specification, the examiner interprets the "informing that the treatment code is inconsistent" to be the same as receiving a nonpayment activity code.

Provost does not teach interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with said nonpayment code set employed by an organization.

Giannini teaches interpreting said received nonpayment code and translating said interpreted received nonpayment code to a code compatible with a predetermined nonpayment code set employed by an organization (Giannini: column 9, lines 61-67 and column 10, lines 1-6). In light of the specification, the examiner interprets the Alternative Billing Code to be nonpayment code.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Gianni with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Giannini discloses that as alternative medicine is brought into mainstream medicine, alternative providers have attempted to use these codes; but their claims are not understood by the payers because accurate descriptions of the services they perform do not exist therein. Furthermore, ICD-9-CM and CPT codes do not identify the practitioner by profession. For these reasons, "dummy billing codes" or codes designed by individual payers to cope with payment for

alternative treatments have been developed by a few carriers which offer payment benefits to alternative medicine (Giannini: column 1, lines 63-67 and column 2, lines 1-6).

Applicant has amended claim 15, providing the same limitations as claim 1. Please see discussion for claim 1 above.

23. Claims 6-11 are rejected under 35 U.S.C. 103(a) as being unpatentable over Provost et al. (U.S. Patent 6,341,265) in view of Diamant et al. (U.S. Patent 5,530,861) and further in view of Pritchard (U.S. Patent 4,491,725).

24. As per claim 6, the method of claim 1 is as described above.

Provost does not teach assigning a time and date identifier to rejected claim data indicating a time and date indicative of *at least one* of (a) a time and date associated with scheduling a task comprising performing processing concerning said rejected claim data, (b) a time and date associated with processing said received notification of claim denial or rejection, (c) a time and date associated with receiving notification of claim denial or rejection, and (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data.

Diamant teaches assigning a time and date identifier to rejected claim data indicating a time and date indicative of *at least one* of (d) a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data (Diamant: column 6, lines 18-24).

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because

“current tools are limited in that they do not define hooks to the actual work performed or to project management tools. For example, they cannot automatically track time spent executing tasks (Diamant: column 1, lines 28-33).”

25. As per claim 7, the method of claim 1 is as described above.

Provost does not teach assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data and initiating generation of a message alerting a user at least one of said period is due to expire at said time and date or said period has expired.

Diamant teaches assigning a time and date identifying expiration of a period assigned to complete performance of said processing concerning said rejected claim data (Diamant: column 6, lines 18-20) and initiating generation of a message alerting a user at least one of said period is due to expire at said time and date (Diamant: column 6, lines 20-24) or said period has expired.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “current tools are limited in that they do not define hooks to the actual work performed or to project management tools. For example, they cannot automatically track time spent executing tasks. Additionally, tools are limited because they do not include triggers for automatically initiating actions in the computing environment based on the task (Diamant: column 1, lines 28-38).”

26. As per claim 8, the method of claim 1 is as described above.

Provost does not teach collating data by at least one of payer organization or reason for claim rejection or denial.

Diamant teaches collating data by at least one of payer organization (Diamant: column 15, lines 13-21). In light of the specification, the examiner interprets “selection of a filter and applying the filter” to be the same as “collating data by payer organization.”

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Provost discloses that “delivery of health care services has shifted from individual physicians to large managed health maintenance organizations. This shift reflects the growing number of medical, dental, and pharmaceutical specialists in a complex variety of health care options and programs. This complexity and specialization has created large administrative systems that coordinate health care providers, administrators, patients, payers, and insurers (Provost: column 1, lines 14-30).

27. As per claim 9, the method of claim 1 is as described above.

Provost does not teach collating rejected claim data by at least one of payer organization, assigned activity code, or type of request for information indicated in a corresponding notification.

Diamant teaches collating rejected claim data by at least one of payer organization (Diamant: column 15, lines 13-21). In light of the specification, the examiner interprets “rejected claim data” to be attached with a task that needs to be performed to resubmit the claim; therefore, the filter, payer organization, is applied to the tasks.

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because Provost discloses that “delivery of health care services has shifted from individual physicians to large managed health maintenance organizations. This shift reflects the growing number of medical, dental, and pharmaceutical specialists in a complex variety of health care options and programs. This complexity and specialization has created large administrative systems that coordinate health care providers, administrators, patients, payers, and insurers (Provost: column 1, lines 14-30).”

28. As per claim 10, the method of claim 1 is as described above.

Provost does not teach acquiring statistics concerning at least one of, (a) type and frequency of claim rejections, (b) type and frequency of claim denials, (c) data identifying success rate of first time claims submissions for an individual payer, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer, (e) data indicating a time duration expected for processing a non-paid claim until re-submission and (f) data identifying a proportion of non-recoverable claims for an individual payer.

Diamant teaches acquiring statistics concerning at least one of, (d) data indicating a time duration expected for processing of a submitted claim for an individual payer (Diamant: column 6, lines 13-17).

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because

“many claims are subject to multiple submission and adjudication cycles, as they are successively created, rejected, and amended. Each cycle may take several weeks or more, and the resulting duplication of effort decreases the efficiency of the health care system” (Provost: column 2, lines 42-49) and therefore acquiring the statistics will help understand the amount of time it takes to successfully submit a claim.

29. As per claim 11, the method of claim 10 is as described above.

Provost does not teach employing said statistics to at least one of modify processing of said rejecting claim data or create a statistical report for an individual payer.

Diamant teaches employing said statistics to at least one of modify processing of said rejecting claim data or create a statistical report for an individual payer (Diamant: column 6, lines 13-17). In light of specification, the examiner interprets “tasktimelog file” to be the same as a “statistical report.”

Therefore, it would have been prima facie obvious to one of ordinary skill in the art at the time of the invention was made to combine the teachings of Provost in view of Diamant with Pritchard. One of ordinary skill would have been motivated to combine these teachings because “many claims are subject to multiple submission and adjudication cycles, as they are successively created, rejected, and amended. Each cycle may take several weeks or more, and the resulting duplication of effort decreases the efficiency of the health care system” (Provost: column 2, lines 42-49) and therefore employing the statistics will help understand the amount of time it takes to successfully submit a claim.

Response to Arguments

30. Applicant's arguments filed for claim 12 have been fully considered but they are not persuasive. Applicant amended claim 12, by adding the limitation claim data accompanied by a denial or rejection notification. Provost fully supports this limitation by showing transmission of information (i.e. notification) to the client computer to inform the medical technician of the result why the submitted claim will not be paid. According to applicant's definition of a denial or rejection notification, the examiner interprets that the whole claim data was returned to the client with the reasons for denial or rejection of the claim. (Provost: column 6, lines 12-15)

31. Applicant's arguments filed for claim 4 have been fully considered but they are not persuasive. Applicant has amended claim 4, by adding the limitation translating nonpayment code to said standard activity code. Giannini fully supports this limitation by showing a conversion table of Alternate Billing Code (i.e. nonpayment code) to specific RVU and conversion factor codes of a given insurance carrier. Based on the review of each table, the insurance carrier can correlate the conversion factor codes with the appropriate service code numbers (i.e. standard activity code, CPT) used by the insurance industry. (Giannini: col. 9, 61-col. 10, 11)

32. Applicant's arguments filed for claim 9 have been fully considered but they are not persuasive. Applicant has amended claim 9, by adding the limitation automatically collating rejected claim data. Diamant fully supports this limitation by filter *automatically* organizing the tasks (i.e. rejected claim data) into an organized task list for the task manager to process.

33. Applicant's arguments filed for claims 6-8, 10-11, 13, and 16 have been fully considered but they are not persuasive.

34. Applicant's arguments with respect to claims 1-3, 5, 14-15, and 17 have been considered but are moot in view of the new ground(s) of rejection.

Response to Amendment

In response, all of the limitations which Applicant disputes as missing in the applied references, including the features newly added in the 02/15/2007 amendment, have been fully addressed by the Examiner as either being fully disclosed or obvious in view of the collective teachings of Provost, Gianni, and newly added reference Pritchard, based on the logic and sound scientific reasoning of one ordinarily skilled in the art at the time of the invention, as detailed in the remarks and explanations given in the preceding sections of the present Office Action and in the prior Office Action (mailed: 11/01/2006), and incorporated herein.

Conclusion

35. **THIS ACTION IS MADE FINAL.** Applicant is reminded of the extension of time policy as set forth in 37 CFR 1.136(a).


A shortened statutory period for reply to this final action is set to expire **THREE MONTHS** from the mailing date of this action. In the event a first reply is filed within **TWO MONTHS** of the mailing date of this final action and the advisory action is not mailed until after the end of the **THREE-MONTH** shortened statutory period, then the shortened statutory period will expire on the date the advisory action is mailed, and any extension fee pursuant to 37 CFR 1.136(a) will be calculated from the mailing date of the advisory action. In no event, however, will the statutory period for reply expire later than **SIX MONTHS** from the mailing date of this final action.

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Sheetal R. Rangrej whose telephone number is 571-270-1368. The examiner can normally be reached on M-F 8:30-5:30.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Joseph Thomas can be reached on 571-272-6776. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see <http://pair-direct.uspto.gov>. Should you have questions on access to the Private PAIR system, contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free). If you would like assistance from a USPTO Customer Service Representative or access to the automated information system, call 800-786-9199 (IN USA OR CANADA) or 571-272-1000.

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4/19/07
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